Case Mix Technical Assistance Document

Overview of the RUGs Process

Department of Medical Assistance Services (DMAS) has established a quarterly cycle for collecting and processing MDS data in order to set rates. Once each quarter DMAS receives a backup tape of the MDS database from Virginia Department of Health (VDH). The backup is received after the allotted time has gone by for nursing facilities to submit assessments to the VDH/CMS system. DMAS will get all assessments that have been submitted with an R.2.b. date on or before the picture date. Please see the flowchart at Attachment 1 that displays how each assessment is classified as either Medicaid or non-Medicaid. The general rule is that assessments are included if the individuals were Medicaid eligible on the picture date. However, there are some situations that deviate from this rule. If individuals meet one of the following criteria, their assessments are not included:

- The individual is a hospice patient.
- The individual is in Specialized Care (SC) – mark S.1.a. = 2 if the resident is a SC resident.
- Medicare Part A is paying for any part of the per diem rate.
- The individual was discharged on the picture date.
- The individual was in the hospital on the picture date.
- Medicaid is not paying for the nursing facility per diem because the individual has improperly transferred property.

The picture date is the last day of the quarter. For example, the picture date for the First Quarter (January through March) is March 31. The provider has 33 days from the date of the report (30 days plus 3 days for mailing from DMAS to the provider) to make any corrections. Changes to MDS data are to be made by submitting a corrected assessment through the CMS/VDH MDS system.

If a facility makes changes to an MDS, they must follow the CMS/VDH correction policies and resubmit the assessment. The Provider Instructions for Making Automated Corrections policy manual provides guidance in correcting MDS data and is available on the CMS website at www.qtso.com/mdsdownload.htm. The facility does not need to communicate to DMAS that a change has been made. When DMAS gets a download of the MDS data, a corrected assessment will be selected for the picture date if it is the most recent assessment available for the resident.

DMAS provides answers to questions concerning Medicaid Case-Mix Nursing Facilities rates and determination of the residents and their status (Medicaid/non-Medicaid) used in the payment system. DMAS developed the “Request for Research” form (Attachment 2) so that consistent and complete information can be sent by the nursing facilities. This form is on the DMAS website and maybe accessed via the 'Search Forms' function. The form is located under the user section - provider, type of form is Long Term Care - Facility and Facilities Based Services; category is Nursing Facilities.

The form may be downloaded from the website; however, since it contains client specific information, it cannot be sent to DMAS electronically. It must be faxed or mailed to the

Facilities and Home Based Services Supervisor. The fax number is 804-371-4986 and the mailing address is 600 East Broad Street, Suite 1300, Richmond, VA 23219.

All CMS required MDS (OBRA and PPS) assessments completed on or before the picture date are included in the resident roster if it is submitted to and accepted by VDH/CMS by the required date. There shall be four picture dates for each calendar year: March 31, June 30, September 30 and December 31. Each resident in each Medicaid-certified nursing facility on the picture date with a completed assessment that has an effective assessment date within the preceding quarter shall be assigned a case-mix index based on the resident's most recent assessment for the picture date as available in the DMAS MDS database. Assessments completed after the picture date are not included, but will be included in the next quarter's assessments.

Sufficient time is allotted for electronic transmission of assessments prior to data being gathered. For example, assume the R.2.b. date on the assessment is 3/30 and the picture date, which is the last day of the quarter, is 3/31:

1. The assessment must be submitted by the facility to the VDH/CMS database by May 1 to be included; and
2. The MDS data will not be downloaded to the DMAS database until approximately May 10.

The time lapses provided should ensure that all assessments are available, assuming that the facility follows the timelines required by CMS for submission of data.

Residents that were Medicaid pending at the time of the picture date, but are later approved retroactive to the picture date, will be included on the resident listing in the draft and/or final MDS report if the eligibility decision is made within 4 ½ months of the picture date. If the eligibility decision is not made within 4½ months of the picture date, the Medicaid resident listing will not include that resident. The resident will be included in the next quarter's assessment.

The DMAS data system is populated from a back-up tape of the VDH data system. The data elements on the DMAS system are the exact replication of the data elements submitted by each facility to the VDH/CMS system. The RUG level for Medicaid is computed by DMAS using the MDS data elements transmitted by the facility to VDH; it is not submitted by the facility to VDH.

The RUGS calculation routine is then run for both the previous and the current calendar quarters. The previous calendar quarter is run to assure that all modifications to the previous quarter data are captured. This routine examines each valid assessment for the picture date and assigns it a RUGs category and the associated Case Mix Index (CMI).

Two reports are generated for each facility – a summary facility report and a resident-specific report. The summary facility report displays:

- Total number of Medicaid residents in the facility
- Average CMI for Medicaid residents in the facility

- Total non-Medicaid residents in the facility
- Average CMI for non-Medicaid residents in the facility
- Average CMI for the facility as a whole
- Total number of Medicaid residents for the entire State
- Average CMI for Medicaid residents in the entire State
- Total non-Medicaid residents in the State
- Average CMI for non-Medicaid residents in the entire State
- Total nursing facility residents in the entire State
- Average CMI for the entire State

Resident-specific reports are produced that provide a detailed listing of the residents in the facility on the picture date. This report includes the following information for each resident: resident name, SSN, date of birth, completion date (R.2.b.), Medicaid/non-Medicaid, RUG classification and CMI score. This report also includes summary information.

Two resident listings are provided for each relevant picture date prior to the use of the CMI information in the settlement process. The first listing is sent after the first run. The second listing is sent five months after the picture date. The second listing, or the revised CMI score based on the RUGs validation review, is the report that is used at cost settlement. The rate formula includes the average of MDS date for the two picture dates.

> Example: For a picture date of March 31, the MDS data are first run in mid-May and a preliminary report is generated. The second time the listing for the picture date of March 31 is run is mid-August and is sent to the provider by the end of August. This second listing for the picture date of March 31, or the revised CMI score based on the RUGs validation review, is the final report that is used at cost settlement.

Contact the DMAS contractor Clifton Gunderson for any questions regarding rates at 804-270-2200.

Documentation Guidelines

The purpose of DMAS validation reviews is to determine if the resident is appropriately assessed for reimbursement and to satisfy the federal requirement for utilization review. The reviews are not the same as quality of care reviews that are conducted by the Virginia Department of Health (VDH). DMAS utilization review staff, when conducting RUGs utilization reviews, will use documentation guidelines.

- DMAS uses The Revised Long Term Care Resident Assessment Instrument User's Manual Version 2.0, December 2002, with all updates, when conducting RUGs utilization reviews (UR). This manual, with the latest updates, can be downloaded at www.cms.hhs.gov/quality/mds20. Providers should regularly monitor the website for changes to the RAI Manual.
- Knowing how to accurately complete the MDS assessment is key to being successful with the Virginia Medicaid case mix classification system. Collecting accurate data, along with following the instructions in the RAI User's Manual, are critical to completing accurate assessments**.**

- If there are questions about how to code MDS items, consult with the state RAI Coordinator at 804-367-2103.

- Clinical documentation that furnishes a picture of the resident's care needs and response to treatment is an accepted standard of practice, is part of good resident care, and staff care planning. For this reason, it is always expected that information contained in the clinical record supports rather than conflicts with the MDS. Completion of the MDS does not remove the facility's responsibility to document a more detailed assessment of particular issues of relevance for the resident or as required by Medicaid to support that the resident met nursing facility criteria and that appropriate reimbursement is provided. (RAI 2.0 version Manual, Chapter 5, page 5.2, State requirements**)**

- Symptoms/conditions/diagnosis/treatments must have occurred and have documentation to support the treatment or condition, within the designated observation period, which includes the full 24 hours of the Assessment Reference Date [A3a]. Consult the RAI Manual for the proper look back period for each item.

- Facility staff is encouraged to review MDS questions and include qualitative, descriptive, and quantifiable documentation in the residents record to support coding on the MDS.

- Documentation must apply to the appropriate observation period and reflect the resident's status on all shifts. Documentation must be signed dated by the appropriate discipline and provide clear concise information regarding the status.

- DMAS will be reviewing the clinical record to ensure that there is documentation present in the clinical record to support and demonstrate that reimbursement was at the appropriate RUGs level.

- If there is no documentation to support MDS coding on a particular item, that item will be re-coded by DMAS for RUG purposes.

Utilization Review Guidelines

DMAS uses a simple random sampling methodology to select records for utilization review. By using this methodology, a sample is selected that reflects the residents in the facility. The reviews provide results that can be used to make assumptions about the accuracy of the MDS data in the facility across all residents. The table below shows the range of the number of charts that will be reviewed based on the number of Medicaid residents in the facility on the given picture date.

Range of Number of Charts Reviewed by Medicaid Occupancy on Given Picture Date

Medicaid Occupancy	Percent Reviewed	Number Reviewed
0-15	100%	15 Maximum
16-50	Up to 30%	15
51-100	30%	15-30
101-300	20%	20-60
301-400	15%	45-60

- The version of the RAI Manual that was in effect when the MDS was completed will be used to determine proper coding.

- Summary statements or related demonstration (i.e. daily flow sheets that document the outcome of intervention taken that benefit the patient), of program areas may be present in the clinical record and will be considered for documentation purposes.

- Supporting documentation for the review period may be found anywhere in the clinical record, e.g. physician's orders, flow sheets, medication records, notes from disciplines other than nursing. Not all MDS/RUGs data will appear on the resident's care plan. Supporting documentation must be signed dated by the appropriate discipline and provide clear concise information regarding the status. It must be found within the applicable look back periods.

- All services claimed on MDS that are provided outside of the nursing facility must have documentation in clinical record. The clinical records must contain appropriate records that document the treatment occurred. For example, IV treatments received at hospitals requires the treatment record (MAR/TAR) from the hospital or clear evidence that it was provided within the look back period. Other examples would include physician progress notes, discharge summary notes, wound care, respiratory treatment, dialysis, injections, Oxygen, radiation, chemo, etc. (Section P of the MDS page 3-182). Documentation from outside sources must contain specifics to prove that the treatment took place during the look back period.

- Listed examples are not limited to the examples given in this technical assistance document. Other examples may be present and specific to a particular resident and their behaviors.

- Late entries to the clinical record will only be considered valid for Medicaid reimbursement purposes if dated prior to, or on, the R2b date. When a pertinent entry was missed or not written in a timely manner, a late entry may be used. If a late entry is written for any MDS item that occurred during that look back period, it must be written up on or before R2B for the Quarterly or the VB2 for the Comprehensive Review.

    - Record the information in the medical record.
        - Identify the new entry as a late entry

- Enter the current date and time – do not try to give the appearance that the entry was made on a previous date or an earlier time.
- Identify or refer to the date and incident for which late entry is written
- If the late entry is used to document an omission, validate the source of additional information as much as possible (where did you get information to write late entry). For example, use of supporting documentation on other facility worksheets or forms.

DMAS will communicate the visit date of the RUGS review in writing approximately 10 calendar days in advance of the visit. This is for notification purposes only and the date is not negotiable. The records selected for review will not be communicated in advance of the visit. DMAS reserves the right to make unannounced visits as deemed necessary by the Department

While on-site for the review, DMAS staff will ask for information if it cannot readily be found in the record. However, all information to support the coding of the MDS must be provided by the facility staff while the UR staff is on-site. The DMAS staff that conducted the review cannot consider additional information that supplements the record that is received at a later time. Any concerns that arise about documentation during the review can be discussed at the exit conference

Following the UR review, the DMAS staff use the information gathered to make resident reclassifications for each of the assessments that had a change for any of the RUG data elements. The facility is provided a summary report of the visit, a copy of the UR form used for each resident, and the classification of those assessments following the review.

Reconsideration

If the changes to your direct operating cost prospective rate resulting from the UR review is a decrease in the prospective rate, you have the right to object to the RUGS classifications of the residents that were changed during the UR review. To appeal these changes the provider must submit, within 30 days of the date of this NPR letter, a Request for Reconsideration of the changes to the RUGS classifications made during the UR review. This Request for Reconsideration must include any supporting documentation of the providers position on the RUGS classifications that were changed by the UR Team and be mailed directly to the:

Facility and Home-Based Services Unit Supervisor
Division of Long Term Care
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219

Further appeal rights will be explained with the reconsideration letter and cost settlement letter.

Case Mix Application

Facility Medicaid CMI is normalized to the state average (state average = 1.000) by dividing the facility Medicaid CMI by the average CMI for Medicaid residents in the State. DMAS contractor Clifton Gunderson uses the normalized CMI in setting the Semi-Annual Prospective Direct Patient Care Operating Rates.

Case mix from one picture date is used in two different ways in Medicaid nursing home rate setting in Virginia: case mix neutralization and case mix adjustment. References to Schedule H below refer to the PIRS 1090 form used for Medicaid cost settlement and rate setting.

> Case mix neutralization-DMAS averages the four facility Medicaid CMIs from the picture dates overlapping the cost report period to calculate a Case Mix Neutralization Factor. DMAS divides the Direct Patient Care Operating Cost Base Rate (Schedule H, line 10) by this factor to get the "neutralized" Direct Patient Care Operating Cost Rate (Schedule H, line 11). DMAS takes the lower of the cost rate or the Title XIX Direct Prospective Peer Group Neutralized Ceiling (Schedule H, line 12).
>
> Case mix adjustment-DMAS averages the two CMIs from the fourth and third most recent picture dates for the First Semiannual Case Mix Adjustment Factor (Schedule H, line 14). DMAS averages the two CMIs from the second and most recent picture dates for the Second Semiannual Case Mix Adjustment Factor (Schedule H, line 14). DMAS multiplies the Case Mix Adjustment Factor times the lower of the ceiling or "neutralized" direct operating rates for each semiannual Direct Patient Care Operating Rate (Schedule H, line 15).

The use of CMIs for case mix neutralization and case mix adjustment have different timing impacts. See the attached chart describing the quarters used for case mix neutralization and case mix adjustment for PFY04. The impact of case mix neutralization and case mix adjustment can be offsetting. A reduced rate in one period may be offset by an increased rate in a subsequent rate period. However, if the neutralized cost is above the ceiling, only case mix adjustment will have an impact on actual reimbursement.

CMI Quarters Used for Provider Fiscal Year 2004 Nursing Facility Rate Setting

If the Cost Reporting Period Ends this Month	Calendar Quarters Used to Calculate Case Mix. Neutralization Factor	Calendar Quarters Used for PFY04 First Semi-Annual Case Mix Adjustment	Calendar Quarters Used for PFY04 Second Semi-Annual Case Mix Adjustment
01/01/2003 Through 01/31/2003	1st Qtr. 2002 2nd Qtr. 2002 3rd Qtr. 2002 4th Qtr. 2002	3rd Qtr. 2002 4th Qtr. 2002	1st Qtr. 2003 2nd Qtr. 2003
02/01/2002 Through 02/28/2002	1st Qtr. 2002 2nd Qtr. 2002 3rd Qtr. 2002 4th Qtr. 2002	3rd Qtr. 2002 4th Qtr. 2002	1st Qtr. 2003 2nd Qtr. 2003
03/01/2003 Through 03/31/2003	1st Qtr. 2002 2nd Qtr. 2002 3rd Qtr. 2002 4th Qtr. 2002	3rd Qtr. 2002 4th Qtr. 2002	1st Qtr. 2003 2nd Qtr. 2003
04/01/2003 Through 04/30/2003	2nd Qtr. 2002 3rd Qtr. 2002 4th Qtr. 2002 1st Qtr. 2003	4th Qtr. 2002 1st Qtr. 2003	2nd Qtr. 2003 3rd Qtr. 2003
05/01/2000 Through 05/31/2003	2nd Qtr. 2002 3rd Qtr. 2002 4th Qtr. 2002 1st Qtr. 2003	4th Qtr. 2002 1st Qtr. 2003	2nd Qtr. 2003 3rd Qtr. 2003
06/01/2003 Through 06/30/2003	2nd Qtr. 2002 3rd Qtr. 2002 4th Qtr. 2002 1st Qtr. 2003	4th Qtr. 2002 1st Qtr. 2003	2nd Qtr. 2003 3rd Qtr. 2003
07/01/2003 Through 07/31/2003	3rd Qtr. 2002 4th Qtr. 2002 1st Qtr. 2003 2nd Qtr. 2003	1st Qtr. 2003 2nd Qtr. 2003	3rd Qtr. 2003 4th Qtr. 2003
08/01/2003 Through 08/31/2000	3rd Qtr. 2002 4th Qtr. 2002 1st Qtr. 2003 2nd Qtr. 2003	1st Qtr. 2003 2nd Qtr. 2003	3rd Qtr. 2003 4th Qtr. 2003
09/01/2003 Through 09/30/2003	3rd Qtr. 2002 4th Qtr. 2002 1st Qtr. 2003 2nd Qtr. 2003	1st Qtr. 2003 2nd Qtr. 2003	3rd Qtr. 2003 4th Qtr. 2003
10/01/2003 Through 10/31/2003	4th Qtr. .2002 1st Qtr. 2003 2nd Qtr. 2003 3rd Qtr. 2003	2nd Qtr. 2003 3rd Qtr. 2003	4th Qtr. 2003 1st Qtr. 2004
11/01/2003 Through 11/30/ 2003	4th Qtr. 2002 1st Qtr. 2003 2nd Qtr. 2003 3rd Qtr. 2003	2nd Qtr. 2003 3rd Qtr. 2003	4th Qtr. 2003 1st Qtr. 2004
12/01/2003 Through 12/31/2003	4th Qtr. 2002 1st Qtr. 2003 2nd Qtr. 2003 3rd Qtr. 2003	2nd Qtr. 2003 3rd Qtr. 2003	4th Qtr. 2003 1st Qtr. 2004

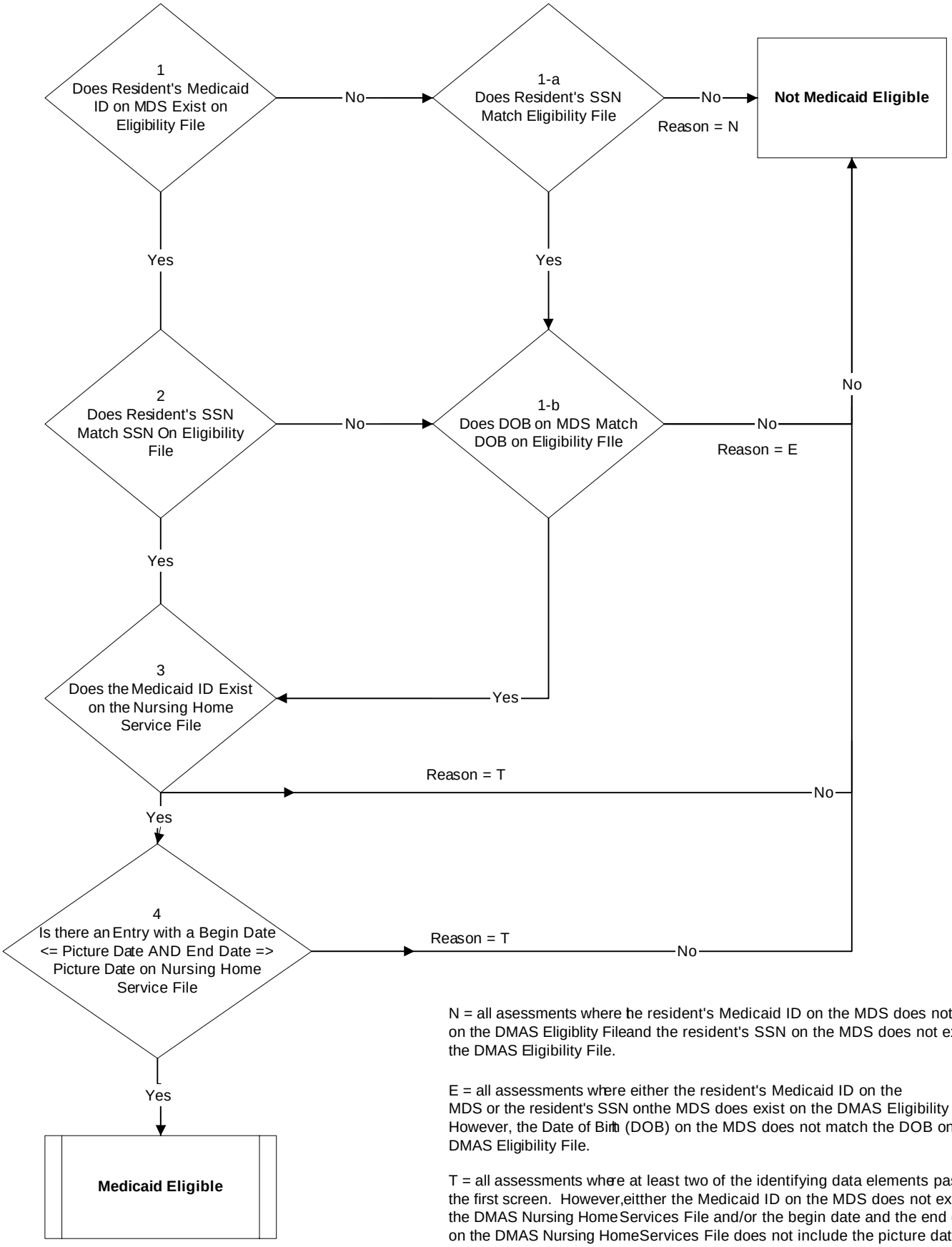
Provider Communication and Training

DMAS will communicate changes and updates to this process through Administrator Letters, Medicaid Bulletins, information on the DMAS website (www.dmas.virginia.govT), and notices to the nursing home associations. DMAS will continue to participate in educational and training sessions in coordination with the Virginia Department of Health (VDH), the Virginia Health Care Association (VHCA), and the Virginia Association of Non-Profit Homes for the Aging (VANHA).

DMAS is open to suggestions about the content of the training and welcomes suggestions about future training.

Attachment 1

MEDICAID ELIGIBILITY DETERMINATION



N = all asessments where the resident's Medicaid ID on the MDS does not exist on the DMAS Eligiblity Fileand the resident's SSN on the MDS does not exist on the DMAS Eligibility File.

E = all assessments where either the resident's Medicaid ID on the MDS or the resident's SSN onthe MDS does exist on the DMAS Eligibility File. However, the Date of Birth (DOB) on the MDS does not match the DOB on the DMAS Eligibility File.

T = all assessments where at least two of the identifying data elements passed the first screen. However,eitther the Medicaid ID on the MDS does not exist on the DMAS Nursing Home Services File and/or the begin date and the end date on the DMAS Nursing HomeServices File does not include the picture date.

Attachment 2

REQUEST FOR RESEARCH
Nursing Facility Providers (RUGs) Issues Only

(Note that one Request for Information Form must be submitted for each resident about whom the facility has a question. This form must be faxed or mailed to Supervisor Facility and Home Based Services Unit at (804) 371-4986. Due to HIPAA requirements, client specific information cannot be mailed electronically. You will receive a response to this request within five working days from the date of your mail or fax.)

Facility Name: _____

Facility Medicaid Number: _____

Contact Name: _____ Contact Phone: _____

Contact email: _____ Contact Fax: _____

Please provide the following information as recorded on the MDS.

Resident Name (First, Last)**: _____**

Resident Medicaid ID: _____ Resident SSN: _____

Resident DOB: _____(mm/dd/yyyy)

Assessment Picture Date: _____

Issue: _____

_____

_____

_____

_____

For DMAS Use Only

Finding:

Date of Facility Notification: